STATE EMS COMMITTEE MEETING
OCTOBER 21, 2015 AT 1:00 PM
3760 S. HIGHLAND DRIVE
SALT LAKE CITY, UTAH 84106
3RD FLOOR AUDITORIUM

Reporter: Susan S. Sprouse

A P P E A R A N C E S

Kris Kemp

Guy Dansie

Jay Dee Downs

Mark Adams

Jeri Johnson

Bob Grow

Margy Swenson

Mike Mathieu

Russell Bradley

Mike Moffitt

Jason Nicholl

October 21, 2015 1:00 p.m.

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KRIS KEMP: Well, I think we can take our seats. We'll get started here in just a couple of minutes or less. Hopefully if we can get started, we can get out maybe a little bit early today. Maybe.

All right. Thank you. And welcome to the State EMS Committee meeting. Today we have quite a full agenda, several informational items and look for some opportunities for questions, and there's a few round table discussion points that have been brought up during our executive session which occurred just about an hour ago.

I'm -- I'm Kris Kemp, the Chair of the Committee, and I think we've all got -- we can run real quick down and just do introductions so everyone knows where everyone is. Why don't we start on this end.

MARGY SWENSON: I'm Margy Swenson. I'm the EMT with Grand County.

BOB GROW: Bob Grow. ER doc at Ogden Regional and Davis Hospitals and medical director of Weber County.

JERI JOHNSON: Jeri Johnson, Wayne County EMT.

MARK ADAMS: Mark Adams, hospital representative from Ogden Regional Medical Center.

JAY DEE DOWN: Jay Downs rural fire chief.

GUY DANSIE: Guy Dansie with the Bureau of EMS &

Preparedness.

MIKE MOFFITT: Mike Moffitt with Gold Cross Ambulance.

RUSSELL BRADLEY: Russell Bradley, Mountain West Medical Center, ER physician, VA Medical Center ER, and rural physician rep.

MIKE MATHIEU: Mike Mathieu, Ogden Fire Chief.

KRIS KEMP: Great. In our packets we have the minutes from our last meeting. We've had an opportunity to review those. I'd open the floor for a motion and second for approval.

MIKE MATHIEU: Motion to approve.

KRIS KEMP: I have a motion. Do we have a second?

MARK ADAMS: Second.

KRIS KEMP: All in favor say aye.

COLLECTIVELY: Aye.

KRIS KEMP: Any opposed? Any abstained? All right. Great. Motion carries.

We'll jump right into our discussion and action items of Rule R426-5 and R426-7. Guy.

GUY DANSIE: Okay. As all of you know, we recently made effective several of our pieces of Rule, including R426-5, and that part of rule contained some new statutory mandates including background check information,

Peer Review Board and some -- and auto-injector use for EpiPens.

Anyways, we've made the rule effective but after doing so, we found that there were some issues. The rule needed to be made effective by October, was our mandate, so we did that. However, as we go back and look through, there were concerns. And so I have a copy of that. Highlighted in yellow are some of those issues. And we've made those amendments in our Rules Task Force and now we're forwarding them to you for your -- your consideration.

So in the handout, if you can see R426-5-2600, epinephrine auto-injector use. The part in yellow, two and three were -- were modified, based on input from the state school board. One of the big issues they had was adding approved trainings referencing those. So we've put -- actually put a link to the website where they will post those approved trainings for the auto-injector use.

Any discussion or issues with that? Okay. Not seeing any, we will move on.

If we look at the back side of that page, R426-5-2700, as we read through that, it was brought to our attention that there were some inconsistencies, some things that were referenced in -- in other codes that were not accurate and so forth. And that -- and we have a

couple of gentlemen here that actually helped us with that, and I don't know if you have any input or anything you'd like to say on the front end. The Rules Task Force met, reworded some of those -- those inconsistencies. Do we want to go through line by line or --

KRIS KEMP: I think they're pretty self-explanatory. I think for those that have the packets, they can review them. If there's any questions, this is our opportunity.

GUY DANSIE: There was a numbering error as well. We tried to correct that.

In my opinion it did not change the content per se, but it clarified the -- the effective language that we currently have. It clarified that. And there's some cases where there were errors and we've corrected those. So, no problem there?

Okay. And then also if you flip back through R426-5-3000 is the EMS Rules Task Force. This is all new language. All of this section. It basically describes what the Rules Task Force is, how it's comprised. It has listed the positions and -- and they're -- and we put it into rule how they function. And that -- we did that to -- to ensure that they were on the same footing as -- as the Peer Review Board. We used the rule language that was previously in this rule to -- and modeled that to --

to fit the Task Force.

And we used the positions that are listed there as actually the actual -- as the positions we currently have. We did this in policy previously and actually the board was represented by Jay Downs, myself and Jolene Whitney, put together the first Task Force. And we went through an application process, selected those applicants. They've been functioning for almost two years. Seems to be going quite well. There were a few of the positions originally that were never filled, and so we just -- we eliminated those from this list.

They felt, the Task Force felt that two consecutive full terms of three years would be sufficient for their -- their group. I'm trying to think if there's anything else in there.

Any questions or -- Jason, were you there as well? I think Jason was there too. It seemed pretty straightforward. I don't -- anyway, it shouldn't be any conflict that I could see in there, but if there is, let me know.

MARK ADAMS: So if I'm reading this correctly, there will be one representative from the EMS Committee on the Rules Task Force.

GUY DANSIE: As a -- as a voting member.

MARK ADAMS: As a voting member.

GUY DANSIE: Right. What -- what we have done in the past -- we actually had Jason -- Jay -- Jay was in a position where he wasn't sure if he could attend some of those meetings, so we asked the committee previously and Jason was selected to be an alternate for that. Jason has come to those meetings as well, and he's been part of the process in the last, what, several --

JASON NICHOL: I'll stop going, though.

GUY DANSIE: We still like Jason there. And as an alternate I think that's a great idea. Myself, I don't vote, but I go and represent the Bureau to remain neutral on those issues. But if there's anything in there that we need to change, let us know, we'll -- if you guys are okay with this, we'll go ahead and we'll forward it to -- through our administrative approval process.

KRIS KEMP: So do we need to --

GUY DANSIE: A motion.

KRIS KEMP: Great. So for R426-5-2600, -2700 and -300, do we have a motion -- or 3000, excuse me -- do we have a motion for these to be approved?

JAY DEE DOWN: So moved by me.

KRIS KEMP: And do we have a second?

BOB GROW: Second.

KRIS KEMP: All in favor say aye.

COLLECTIVELY: Aye.

KRIS KEMP: Any opposed? And any abstained? Great.

Now let's talk about R426-7.

GUY DANSIE: Okay. R426-7 is our rule for data, for data systems. And Shari Hunsaker is actually our data manager, program manager. So she was -- she consulted with the Rules Task Force. We went through and pretty much, I think, verbatim made the changes that Shari has suggested.

One of the issues was timeliness of reports, and that was in Part 5 you'll see where it's underlined. We wanted more timely data. There was almost a two-month time that could be used by providers to submit data in order to make it more timely for the hospital use -- am I saying this correctly? We moved that -- that any data for a two-week period or the first through the 15th would have two more weeks to submit. And then from the -- anyway, you can read how it's worded. But that was probably the only thing that was discussed at length.

SHARI HUNSAKER: The existing rule allows for an incident that occurs on October 1st to not be reported until December 1st. Because the rule currently reads data must be submitted within 30 days of the end of the month in which the instance occurred.

So if an incident occurs on October 1st, it has

to be submitted by December 1st. If it occurs on October 31st, it still has to be -- submitted by December 1st.

So what we're trying to do is to get those submissions coming in more timely in large part to help the hospital users who are trying to pull up these run tickets and aren't able to do their job because they can't locate the copy. And although a hard copy of the report may often be left in the ED when the patient is transferred over there, that paper copy does not get into the electronic medical record or facilitate its access by other hospital users. And so we are trying to get our data submitted in a more timely manner.

GUY DANSIE: Okay. And then also if you turn over on Part 5-B, one of the things that was added is a validation of a non-state provided system. I -- in order to make sure the interface is successful between our data system and the user, the provider's data system, there's a validation process that needs to be followed.

SHARI HUNSAKER: I need to go through, but -- so what happens is that if an agency changes vendors, an agency in Utah County switched over to Image Trends several months ago, but they never notified me. So they haven't submitted records since July, because they just barely found out that the reason their records weren't

automatically coming into Polaris is that they didn't have rights to do that. And until I can verify that all of the values that they are submitting for the various data elements are accurate and consistent with the NEMSIS data dictionary, we don't grant that -- those rights just to maintain data quality.

But there was nothing in rule that required that. And during my tenure as data manager, I've had maybe a dozen instances similar to this agency in Utah County, and then we're behind the eight ball trying to get everything done as quickly as possible so that we can get clean data from the agencies. And I just felt that since that is one of our requirements, it would -- we would be well-served to include that language in administrative rule.

GUY DANSIE: Okay. Good. Also, and this is probably something that I -- it's probably news to Shari, because one of the suggestions, if we read down further in the rule it goes to Part 7 and then it talks about national demographic data elements. And we've listed those out previously in rule. And I received approval through the AG's office to pull that out of the rule. And so the -- the language you see, all of the data elements, we will pull out of this rule, it hasn't been drafted that way for your review today, but I will pull those out and

we can list those on our website.

SHARI HUNSAKER: Yeah, we'll just reference the NEMSIS data dictionary.

GUY DANSIE: Okay.

SHARI HUNSAKER: And an Excel spreadsheet that indicates which NEMSIS optional elements are required by the state.

GUY DANSIE: Okay. So there would be a change in the draft you see before you, that we would pull that list out of this -- out of the written rule and put it into a -- to a policy and publish the policy. That way we are able to change those data elements without going through a rule making process.

Any questions or issues with that?

KRIS KEMP: Just in preparation for that, I think it would be good to have members of this committee meet with Shari to determine what optional values we are going to collect. And before we publish them on the website.

GUY DANSIE: Okay. To approve the --

SHARI HUNSAKER: I -- I inherited from Josh Legler the results of a work group that had gone through all of the NEMSIS Version 3 elements and had decided what those elements were going to be. That list was orig- -- was presented to this committee a couple of years ago and

approved, but I can certainly bring it back up.

But, I mean, I've got the historical documentation where that has already happened, but then there was a delay in implementing NEMSIS Version 3 because of our acquiring a new data system. But I can certainly bring those results back.

GUY DANSIE: We were talking about --

KRIS KEMP: Take the temperature of the committee, that's fine, I think it's a good idea to get together.

SHARI HUNSAKER: Okay. I just wanted to make it clear that I wasn't going off making up my own willy-nilly list.

MIKE MOFFITT: Thank you. Yeah, I just wanted to make two comments.

One is in 5-A and 5-B where one says for EMS providers directly using reporting systems provided by the department, they are considered submitted, blah, blah, blah. And B for emergency providers using reporting system other than that provided by the department, they have to obtain some kind of validation.

I think that could all be shortened into one subparagraph that just says all EMS providers have to meet the requirement rather than -- it almost to me reads like go out and get our approved software and you'll be more

favored than if you have someone else's software, when all software providers today have to meet NEMSIS 3 data elements. I think, we're getting a little --

SHARI HUNSAKER: Certainly, we can do that.

MIKE MOFFITT: -- getting a little too pointed, if you know. It just reads weird. And I think just to say all EMS providers submitting electronically must have their -- their software vendor validated with the state.

SHARI HUNSAKER: But that's not true. That statement is not correct.

MIKE MOFFITT: Which -- which one?

SHARI HUNSAKER: Because if you're using -- if you're using Image Trend, which the state is in the contracting phase now to sign a contract with Image Trend, if you are a small rural agency and you are using Image Trend on the web using the URL that the state gives you, and directly entering the data, you don't have to do any validation because I've already done it in all of my business rules and setups.

It's only for those agencies that are using either their own purchased copy of Image Trend or they're using ESO or emergency recording, Golden Hour, those are the -- the issues that need to be validated. Even if you're using Image Trend --

MIKE MOFFITT: But the rule only has to say

providers that are electronically submitting their data have to make sure that their -- their software is validated by the state. You've already done it for Image Trend, that's fine. You don't have to redo it.

SHARI HUNSAKER: I've only done it for those that are using our version of Image Trend.

MIKE MOFFITT: But -- but it should be everybody has to make sure that they're validated and their data comes in clean. Not -- this kind of gives a -- this is special and this -- you have to jump through more hoops when theoretically they should be the same.

So the rule should just be if you're submitting electronically, you have to make sure that it's validated by the state, that it comes in correctly. It just -- I mean, to be an all encompassing bland rule, not saying that the state's got something better than the other guy's got, or make it look that way, should just read that whoever you're using has to pass state approval.

And whether you approve it, you may only have to do that once and that may be for the state provided. They're already approved, use it, you're great. If you're going to use Zole or Image Trend, full, you know, the full retail version, then you already know it works, so you just have to know what they're using and say, yeah, that works. So it just -- it's a one encompassing rule rather

than two separate rules.

SHARI HUNSAKER: Well, I will yield to the decision of the committee.

MIKE MOFFITT: That's just my thought.

And on the other -- on the data points, we did discuss taking the data points out of the written rules so that they could be changed at any time during the year without having to go through the whole rule making process. And along with that I think, I agree with Jason, we just said the committee would like to have a small task force to go over those points before we make those changes so that we know why we're doing them and how they're going to relate to the field.

SHARI HUNSAKER: And that's fine. May I ask that that task force be convened before the next EMS Committee meeting?

MIKE MOFFITT: Oh, sure.

SHARI HUNSAKER: Because I need to have those elements tied down --

MIKE MOFFITT: Sure.

SHARI HUNSAKER: -- within the next --

MIKE MOFFITT: You know, and I think part of it is, you know, we need to approve it as a committee and we need to put some names on that task force and then set a date. But the intent would be that it would meet prior --

prior to EMS Committee meetings to get any changes and only meet if there are necessary changes that need to be talked about, but prior to get those changes thoroughly discussed and approved before they go to the EMS Committee.

KRIS KEMP: Chief Mathieu, do you have something?

MIKE MATHIEU: Yeah, just one comment in support of what Shari's trying to do additionally. This last year with the passage of the house bill that had to deal with the ambulance Medicaid assessment, drives even more importantly, well, I mean, not more importantly, but it will come into question is that in the past a lot of times this data has been great in terms of holistically looking at EMS services in the state and hopefully it drives good data during the decisions. But now with the Medicaid assessment, it's extremely important that the numbers of all providers and transport providers are accurate because now it means money, it means assessment. And that already has started to come up with this last week. And so it's even that more important because providers will be asking those questions, and this numbering information needs to be valid. And that's very much supporting Shari in her terms in trying to get these numbers accurate.

SHARI HUNSAKER: And as it happens, because of

some major data glitches that we have identified recently, two of the largest agencies in the state are going to see almost a twofold increase in what their medical assessment was because we've identified that they've been under-reporting their records just because there was some software glitches. It wasn't an intentional under-reporting, it just was something that we just uncovered different vendors, different agencies.

MIKE MATHIEU: There's going to be a lot more eyes paying attention to these numbers now because of the financial consequences, so we want to make sure they're accurate.

KRIS KEMP: All right. And I think -- we're going to discuss that a little bit further in the round table discussion and the Medicaid assessments in further clarifying that.

Dr. Taillac, did you have something?

DR. PETER TAILLAC: Just a quick sort of suggestion, perhaps, for the committee. I hear from Shari that she has some deadlines she has to meet to get the contract done. If we're pulling out the data elements from the rule anyway, might I suggest we let Shari proceed with the elements that are currently there and then look at them sort of in a timely fashion because they can be changed any time.

MIKE MOFFITT: Sure.

DR. PETER TAILLAC: So we don't delay the implementation of the schedule.

MIKE MOFFITT: And I think that's the whole spirit of doing -- pulling them out of the rule and moving it so that we can discuss and manipulate the data elements that we collect as we go, rather than have to go through this whole process.

DR. PETER TAILLAC: Okay. And you don't have to do it within 30 days or whatever?

MIKE MOFFITT: Right.

SHARI HUNSAKER: I can give Suzanne the list of the NEMSIS 3 data elements that we've already identified, and she can distribute that to the Committee, along with my contact information so that we can get this ball rolling.

KRIS KEMP: All right. So we'll need to have a motion based on what we've just discussed. Mr. Moffitt?

MIKE MOFFITT: I'd like to make a motion.

KRIS KEMP: All right.

MIKE MOFFITT: Let me try to get this all in one --

KRIS KEMP: Breath.

MIKE MOFFITT: -- motion. I would make a motion that we role paragraph, subparagraphs 5-A and 5-B into one

paragraph that just generically states that all reporting software needs to be approved by the state or validated by the state ITS department -- or what do you call yourself?

SHARI HUNSAKER: I'm the data manager.

MIKE MOFFITT: Data manager. Thank you.

And also that we remove the data elements from the written rule and we can change -- so that we can change those as we go. But we also create a task force from the EMS Committee that will meet and discuss as needed data elements that need to be dropped or included in the list going forward.

And that we accept this list as written now so that we can move forward with your processes, Shari, and then we'll come back. And if we have any changes to make by the next meeting in January, we'll make those then.

SHARI HUNSAKER: May I just make one more comment? I was going to come to this group and ask if we could have a workforce or a task force specifically to address ongoing data quality issues. And so perhaps the motion could read that we form a data task force and that could include working on data elements as well as data quality issues.

MIKE MOFFITT: Let me expand on the task force that I would like the EMS Committee to create from the EMS Committee, that we also look at data quality and other

data collection issues to streamline and improve that process going forward.

SHARI HUNSAKER: Thank you.

KRIS KEMP: We have an amended motion. Do we have a second?

MIKE MATHIEU: Second.

KRIS KEMP: We have a second. All in favor?

COLLECTIVELY: Aye.

KRIS KEMP: Any opposed? And any abstained? All right. Thank you.

GUY DANSIE: Somebody left a phone on the back table. No takers? All right.

KRIS KEMP: All right. We'll move into the subcommittee reports and action items. We'll start first with Professional Development Update. Is Von here?

JASON NICHOL: Yeah, he's in the back.

VON JOHNSON: Okay. In our last meeting we were tasked with the task of figuring out if we could possibly do away with the IA certification, dropping those individuals that are already IA certified back to advanced with the agencies that are currently using them to have waivers put in place to maintain the standard of care that they were already providing.

We discussed this at length. We finally came up with the idea of doing some research on that and that our

committee members take that out and get back with me with any recommendations or anything like that.

What we came up with was in looking at it, it appears that there's only two drugs, adenosine and Lasix that would be involved, and the procedure of intubation. So we felt like we could support that in dropping back to the advanced level and providing waivers for those that wanted to continue with that to be able to do so.

The one concern that we had was that if we did that, we need to make sure that any other agencies that wanted to be able to train to that level would be allowed to do so with the waivers that were in place for the two agencies that are currently doing it, so we're not writing separate sets of rules for the two agencies that are currently involved.

KRIS KEMP: Okay. Thanks for the report. I think there's a little bit more detail to come from that as well; specifically, around those agencies that were grandfathered as IA in producing rule explanation and language that will state specifically that, that this won't be open to any agency. It's really just what those agencies that have been grandfathered as IA, that what their plan would be is to drop down as the individual -- individuals will be certified as advanced EMTs, however, the agencies will remain certified as IA. So the agencies

don't lose that certification, but the individuals drop down. And then through the waiver use those individuals that already have the IA certification can maintain that. And those that aren't, if they are a part of that agency specifically, they can then be trained up to through the use of the waiver.

That language is still yet to be drawn up and it's going to be coming to you, I believe through the -- through the department as soon as we get that language put together from those two agencies. Their recommended language at least.

Guy, do you have anything further to explain?

GUY DANSIE: No, I just -- we did mention that, and I think Don Marrelli is here, and we talked about that a little bit in the Rules Task Force, just put the idea out on the table. And we really haven't gone anywhere with that idea at that point.

I wanted to make sure that the two licensed providers are Carbon and Wasatch, make sure that they have what they need and then we would look at drafting that rule, but it hasn't been done yet.

KRIS KEMP: Yeah. And it's still in the processing stage from what I understand.

Shari.

SHARI HUNSAKER: In the NEMSIS Version 3 data

standard, there is no equivalent to an intermediate advanced service level. And so I'd like clarification as to how to report that back to the national EMS information system. Are we going to report them as advanced?

KRIS KEMP: Yes.

SHARI HUNSAKER: Okay.

KRIS KEMP: Because that's what the individual to be certified as, and they'll be operating under waivers to do any other procedures.

SHARI HUNSAKER: But the agency service level is an agency element. So each agency submits to the national database what their service level is. I just need to know which -- how you want that reported nationally.

KRIS KEMP: We'll get back to you on that.

SHARI HUNSAKER: Okay.

KRIS KEMP: So, Von, with that, when that language is available, we'll present it to the Professional Task Force, Professional Development and the Rules Task Force, I think those are the two areas that will have that language to be able to work on and look over and see if that fits with the principles at play here. Okay? Anything else?

VON JOHNSON: That's all I have, unless you guys have any assignments for us.

KRIS KEMP: I think that will do for now.

VON JOHNSON: Okay.

KRIS KEMP: All right. Operations update. Eric?

ERIC BAUMAN: Okay. Well, the operation subcommittee is continuing to work on the catastrophic earthquake scenario, and that's our portion of the ESFA triage treatment and patients involved.

So we had a really productive meeting with local emergency managers in September. That's allowed us to see some gaps in our plan. And it allows us to keep developing the plan moving forward. We're on target, on schedule to have that completed and ready to present in January. So things are moving forward very well there.

The second item -- the second -- is that better?

SUZANNE BARTON: You might need to turn it on.

ERIC BAUMAN: Anyway -- there we go. Second item is mobile innovated healthcare. We had a presentation through Jeremy Schultz from Dixie Regional, and he educated us on his program. And we'll continue to reach out soon to both Salt Lake City Fire and West Jordan Fire to look at their models that they're pursuing.

The third item was body cameras for EMS. We have broke this down into three different areas. So there's -- the first area is a telemedicine, which the committee feels like we need to keep looking at the

capabilities of telemedicine. It's well supported with the hospitals and integrating EMS into that way.

In terms of body cameras, the second -- which is the second area, there's really not a lot of programs nationally that are utilizing these. The research doesn't support it. So the Committee recommendation is not to move forward on body cameras for EMS personnel at this time.

And then the third category, there was box cameras for ambulances. And we want to continue to look at research on box cameras and see if there's a benefit versus the risk and the liabilities that may go on with that.

And last, and this will be our priority moving forward, the committee will be working on a template for cost, quality and access for the licensure process. And as we finish up, we'll begin on that in November, in our November meeting. And as we finish the catastrophic earthquake and that comes to a close, this will be our No. 1 priority. So we'll be working on that and reporting back to you soon.

Any other assignments or any questions on any of these items?

GUY DANSIE: I just wanted to add a couple of things. I just attended the National Association for EMS

State Officials. A couple of the items that you're working on are actually very big items with their group, especially the integrated healthcare, the mobile integrated healthcare.

And so I'm just thinking, if you -- just to make you aware of that in the group that there's some resources and maybe talk offline later.

Also there's an action -- an initiative that NHTSA is providing some funding to NASEMSO to do a crosswalk of a simplified version of the differences in ambulance standards, vehicle standards. I know that's something the operation committee has worked on for -- off and on for the last couple of years. It looks like there will be some progress made finally in that area.

I guess NFPA has got a new version coming out in January, I believe, and Cass has worked on their standard, and it's supposed -- the final is supposed to be released in we were told 60 to 90 days. So that would give you a little something to chew on as far as that goes. Because eventually we have to move -- well, we don't have to, but we probably should move away from the old KKK standard and adopt one of these new standards so that the -- and nationally that's been a big challenge. But that's coming down the line. So just to give you a heads up.

ERIC BAUMAN: Great. Thank you. Are there any

other assignments or any other questions from the Committee? All right. Thank you.

KRIS KEMP: All right. Thank you. We'll move into the informational items and towards the end we may find some additional assignments that we have for our subcommittees. But for -- to start off -- oh, we have grants. There it is, grants.

JASON NICHOL: We just wanted to skip that.

KRIS KEMP: Heartache. EMS Grant Subcommittee. That may have been the shortest report ever.

JASON NICHOL: Complaining?

BOB GROW: Have you ever seen Chief Mathieu pose while doing karaoke? It's a beautiful thing.

GUY DANSIE: Jay was just asking me to do some.

RON MORRIS: Grant subcommittee report, we are going to recommend some pretty major changes to the grants and the way they are done. As you remember last cycle, the grants have shrunk down the amount to about a third of what we -- in our hay day if you will, had to allocate throughout the state.

Last cycle we recommended that they only be per capita only and no competitive cycle with that, which went out and was done. We met in September, went over the rules and tried to come up with something that we think will be fair and equitable for everybody across the board.

Recommendation, I'll try and make this as quick as I can. Recommendation is with the money we have, we would like to give $1,500 to everyone that applies for the use for CME and continuing education. And then split the remainder 50 percent into per capita and 50 percent into competitive.

As we look through the rules, we have had some amounts set for how much an agency could get for, say, defibrillators. We're down about two-thirds as I mentioned of what we have available. So we went through and cut most of those down to about the same amount. We cut them by two-thirds. And then we went through the categories that are available and we cut several categories out that we felt like we could not adequately fund.

One example would be ambulances. In the past we've given somewhere between 20 to 25. One year we gave $30,000 for an ambulance. An ambulance nowadays is somewhere between 130 and $150,000. We felt like if the 20 grand was the difference between someone purchasing an ambulance or not, they're probably not going to get it anyway. And by the time we fund three, four or five ambulance requests, we've eaten up a huge part of the competitive grants. So we cut ambulance out of it.

We cut communications out of it, and really left

what we feel are the meat and potatoes which was continuing education, CME, and equipment purchases for the competitive portion of that.

So those are kind of in a nutshell the changes that we are recommending. They are fairly drastic, but I think with the money that we have, it's probably the best that we can do with what we have left available.

I'd be happy to answer questions.

KRIS KEMP: Questions from the Committee?

Well, I imagine we have to approve this from the Grant Subcommittee.

GUY DANSIE: Yeah.

KRIS KEMP: Kind of a rough pill to swallow, I imagine.

MIKE MATHIEU: I would make a motion to approve. And as one of the committee members commented, this is just the harsh reality we're dealing with. We used to have $1.8 million and we just don't have it anymore and we'd rather not waste provider's times and efforts competing for the money that's really not there. And so we're trying to stretch it as far as we can to as many people as we can with what little money we have left. So my motion would be to approve as presented.

KRIS KEMP: We have a motion. Do we have a second?

RON MORRIS: One caveat if I could, Dr. Kemp. The committee, we're certainly more than happy to look if we -- somehow the money grows again, to going back to where we were at one point, but for now that's the best we can do.

KRIS KEMP: Okay. So we have a motion open. Do we have a second?

BOB GROW: Second.

KRIS KEMP: All in favor say aye.

COLLECTIVELY: Aye.

KRIS KEMP: And any opposed? Any abstained? Okay. Thank you.

Well, now we'll move into informational items, Pediatric Vital Signs Abstract for the EMSC/Trauma Performance Improvement Initiative. Dr. Hilary Hewes.

SHARI HUNSAKER: Kris, she won't be here until two.

KRIS KEMP: Until two?

MIKE MOFFITT: We might be done.

DR. PETER TAILLAC: It's going to take a little bit of shine off of it.

KRIS KEMP: We'll put that off a little bit. EMS Provider GIS Service Area Software Demo. Shari?

SHARI HUNSAKER: I'm not prepared. I'm not hooked up to do a demo, but I can tell you this. About a

year ago, Matt Peters from the AGRC, which is part of DTS within the state of Utah, came and showed you what we could do with a mapping tool. I'm happy to -- and tell you that that mapping tool has been fully developed, was moved into production and the link is now on our website.

What it allows any user to do is to, for example, I want to look at a list of all agencies in the state with a paramedic service level. I can put in that service level and click search, and all of those agencies, a list appears of all of them, and all of their boundaries are highlighted in the map.

I can search by -- for a county. So if I put in Cache County, I then get a list of all of the licensed providers within Cache County.

I can search for a particular address to see which agencies would respond to a given address. And agencies can go in and put in their agency name and be able to get a map of their service areas.

And there are tools included. A help document is included. A mechanism whereby agencies can report problems back to AGRC.

The Bureau did the upfront development costs. Ongoing maintenance for the map is going to be taken care of through the AGRC's 911 grant. So we won't have any additional expenses coming out of the Bureau. And this

satisfies the requirement that we were given as a result of the legislative audit. So I'm dancing on the inside.

KRIS KEMP: We can tell.

SHARI HUNSAKER: It -- it was -- it's a big deal. So -- and I'm more than happy to send out the URL and the help document so you can play to your hearts content.

KRIS KEMP: Please do. Would you mind sending that to all the Committee members?

SHARI HUNSAKER: I would be more than happy to.

KRIS KEMP: Great. Thank you. Dr. Taillac and Dr. Youngquist, Beta Blocker Use for Refractory Ventricular Fibrillation in Cardiac Arrest.

DR. PETER TAILLAC: So I'm going to introduce Scott Youngquist, who I think most of you know who's the medical director for Salt Lake City Fire. And this -- Scott approached me, I don't know, maybe a year ago now, to consider a variance to alter the difficult ventricular fibrillation patient's care. And I suggested this would be a good pilot project based on our rule regarding pilot projects and variances. So I'll turn the time over to Scott, and I'm happy to answer questions as well. He's the expert.

DR. SCOTT YOUNGQUIST: Thanks. All right. Thank you. Is this working? Yeah. Can you hear this?

So the idea here is, we have about 33 percent of our cardiac arrest victims have an initial shockable rhythm. And a little over half of those require multiple shocks because either initial shocks don't terminate the ventricular fibrillation or it recurs, so they have either recurrent or refractory ventricular fibrillation.

We know that the burns through intracellular energy substrate at about four times resting metabolic rate. So once that's gone, the patient's in asystole, it's very difficult to get them back.

So the idea here is to try to reduce ischemic time and achieve a return spontaneous defibrillation through successful defibrillation as soon as possible.

Now, there's a huge amount of animal data suggesting that beta blockers are beneficial in this setting, in particular, ventricular fibrillation in cardiac arrest. There is some human case series as well in patients who failed standard ALS resuscitation were brought to the emergency department and then given esmolol in the emergency department with survival benefit in those case series as well. So there's no randomized trials to support the use of esmolol, but we already give a beta blocker currently and that's amiodarone. Many people believe that the beneficial effect if there is any of amiodarone is its beta blocking activity. Amiodarone is a

big sledgehammer for a very small nail because it also blocks sodium, potassium, calcium channels as well.

And when given in bolus dosing as we do in -- currently in cardiac arrest is associated with hypotension, it's a vasodilator.

So there are -- amiodarone, as you know, has never been proven to improve survival in hospital discharge, but does get patients out of the efforts successfully.

So we'd like to pilot esmolol. It's a very cardioselective beta blocker. So it targets beta receptors on the heart. And coincidentally this is also considered to be a harmful effect of epinephrine. We try to achieve vasoconstriction through its alpha effects, but the beta effects are considered to cause some cardiac toxicity. And the epinephrine we're giving during the cardiac arrest also increases the chances that we'll get recurrent ventricular fibrillation and tachycardia.

So it makes a lot of sense. There are other agencies using beta blockers in this setting, not many. Out of Wake County in North Carolina, there are agencies using metoprolol. They have not published any results on their use, but this is based on their discussions with electrophysiologists about what should we do when initial shocks don't work for these victims.

As I mentioned, we're already using amiodarone in large part because of its beta blocking effects. So this would be a more tailored approach to terminating ventricular fibrillation, something I would certainly do in the emergency department, I would try. If you look at, you know, experts, they will recommend this approach in the patient who is refractured.

So that's the idea. It's not currently on our list. And the other nice thing about it, it has a very short half-life so its affects wear off quickly. It's not something that's going to cause cardiac depression for a long time after return to spontaneous circulation. The half-life is nine minutes. I don't know if you know the half-life for amiodarone. It's about 40 days. So this is a quick on, quick off medication. It can be administered through -- classically through bolus dosing followed by a drip because it's such a quick on and off medication, but we're proposing to give it as a bolus, see if it works, repeat the bolus once if it hasn't worked and then switch.

So any questions on that I can answer?

MARGY SWENSON: You do it in place of your -- in an ACLS protocol, in place of the first amiodarone dose?

DR. SCOTT YOUNGQUIST: Yes.

MARGY SWENSON: Doing it one time?

DR. SCOTT YOUNGQUIST: No, it would be up to two

doses. So it's a little bit below the standard loading dose because it comes in 100 milligrams. So the idea would be to give half of that. A normal loading dose would be one milligram per kilogram so it would be 70 kilovolts, it would be a little bit below that, and to finish off the 100-milligram injectable if the first two bolus doses didn't work.

We're -- obviously be tracking these victims and their outcomes and comparing them to our historical success with amiodarone.

DR. PETER TAILLAC: Can you address Wake County's experience at all?

DR. SCOTT YOUNGQUIST: There's -- you know, they've got a throw the kitchen seat at it approach, so it includes procainamide, which we don't use also, but also metoprolol. And as I've said, they haven't had enough experience to publish anything on it before.

They also do things like double sequential defibrillation. So they'll put on two pads and charge up two defibrillators and shock the victim, if they haven't been able to achieve termination of VF after, I believe three shocks or something. There's a little bit of variable with it.

So it's an aggressive approach to terminating ventricular fibrillation. We think that it's safe given

that we're already giving beta blockers for termination of VF in the form of amiodarone and this medication's not expensive, it's a generic medication, but we think based on case series in the animal literature it could be beneficial.

KRIS KEMP: What approval process have you gone through so far through other avenues or hospitals, things like that?

DR. SCOTT YOUNGQUIST: Well, we haven't gone through any hospitals. We have a current RB exemption to study the introduction of new medications, devices in a pre-hospital setting. This is not a randomized trial. It wouldn't be randomizing the patients to the therapy, but it's based on the judgment of the directors involved and Peter Taillac believing it could be beneficial to use it.

KRIS KEMP: Could you remind us again the mortality rate of untreated V-fib in a general population?

DR. SCOTT YOUNGQUIST: Untreated V-fib is 100 percent fatal.

KRIS KEMP: So what we're doing is maybe perhaps providing someone a little less chance of death?

DR. SCOTT YOUNGQUIST: Yes.

KRIS KEMP: Sounds like a good idea.

DR. SCOTT YOUNGQUIST: VF is the most likely to survive if we do things correctly. So that's good.

KRIS KEMP: Other questions?

MIKE MOFFITT: What's -- what's your anticipated number of patients in a year that you'll do this?

DR. SCOTT YOUNGQUIST: This would be probably 15 patients in Salt Lake City Fire Department, I'm guessing. Maybe a little bit more.

DR. PETER TAILLAC: We -- I would tend to add West Valley City Fire after checking with the chief that it's okay to try and increase the number of patients that would be treated this way.

MIKE MOFFITT: So we may in a year hear about 30 patients or so?

DR. PETER TAILLAC: I would say 15 plus, yeah, probably another 10 or 15. And if other agencies are interested in participating, we could make it broader potentially.

KRIS KEMP: And the end point of your study is what?

DR. SCOTT YOUNGQUIST: Well, when you say "study", I'm a little hesitant to certify it as a study. It's certainly a pilot project. We're very interested in the rate of return to spontaneous circulation survival of hospital admissions throughout the discharge. We currently track all those things, including their neurologic status at discharge. So we won't have a sample

size sufficient to make this into a well powered study, but this is, I think the next step in figuring out if -- what has worked in the emergency department works in the field.

DR. PETER TAILLAC: Typically a pilot project is by rule good for two years and then it's evaluated at the one year point and then generally terminated unless extended for two years.

KRIS KEMP: Other questions?

MIKE MATHIEU: So at the end of this, if we approve this as a pilot project, would we anticipate in one year or two years you're coming back and giving us a report on the successes or failures?

DR. SCOTT YOUNGQUIST: Absolutely.

DR. PETER TAILLAC: We're required to at one year, give a report.

And I want to point out to the Committee as well, this, if approved by you, this must be presented to the state IRB for approval as well.

KRIS KEMP: Any other questions? Do we have a motion?

MIKE MOFFITT: I'll make a motion. I'd like to make a motion that we approve this further, for a pilot project with a two-year timeframe with a report in at least no longer than a year, mid point.

KRIS KEMP: Do we have a second?

MARGY SWENSON: Second.

KRIS KEMP: All in favor say aye.

COLLECTIVELY: Aye.

KRIS KEMP: Any opposed? Any abstained? Sounds great. Can't wait to hear from it.

DR. SCOTT YOUNGQUIST: Thanks.

KRIS KEMP: We can move on down. We'll continue with the agenda to Behavioral Health Interfacility Transports. Alton Giles.

GUY DANSIE: I'd just like to introduce Alton a little bit. And his people that work with him. We were approached some -- sometime ago about a van service that Alton is running. And we've informed him that we don't regulate that in statute. In statute we regulate ambulance services. And Alton's worked closely with the department to try to make sure that he's not stepping on to that, over that line into an ambulance service.

And we thought it would be a good idea to bring him in because there has been some concerns, and we'd like to just discuss that and thank him for coming here to do this because he's not required to. But we want to make sure that we had a clear understanding with the Committee and with -- with their service and things like that, so we're all on the same page.

Okay. Did that help you go ahead?

ALTON GILES: Yeah.

GUY DANSIE: Okay.

KRISTY KIMBALL: My name is Kristy Kimball. I'm an attorney that specializes in healthcare law, and I've been representing Guardian for the last three years, so from the inception of the company. So they just asked me since I've been involved since the very beginning if I could kind of give an overview of, you know, the company, the services they provide.

And again, I just wanted to emphasize, as I've talked to Guy and Paul Patrick with the Bureau of EMS, that again, the services that Guardian is providing are non-emergent transportation services, they are not emergent. And so again, while we're not regulated by the Bureau of Emergency Services, you know, nor this Committee per se, we felt it's really important to be proactive rather than reactive and try and resolve any concerns that may come up before, you know, it creates any bigger issue than need be.

But given that introduction, I just wanted to again say that Guardian was formed in 2013, and they provide only non-emergent transportation services. They focus mainly on behavioral health patients, and they're transporting patients between medical facilities, clinics

and for court appearances.

Some of the things -- Guardian was founded again in 2013. Again, there was significant communication with the Bureau of EMS even though they didn't have to communicate or coordinate with the Bureau of EMS, they wanted to make sure they avoided any kind of pitfalls or issues and that they were looking at the interpretation, the Bureau's own interpretation of what it meant to be emergent services under the statute and make sure that what -- the services they were providing did not trigger any concerns for the Bureau whatsoever.

The whole point is that for non-emergent patients, right, that if these are truly non-emergent patients, oftentimes hospital systems are absorbing significant costs to transport non-emergent patients, but they're paying emergent transportation prices for those patients.

And so, you know, in talking again with the Bureau over the last few years, you know, and my clients, they felt like this was an area that would really serve the public's interest and healthcare's interest by driving some of the costs down to transport patients that are truly non-emergent patients. But at the same time, if we're really looking at the best interest of the public, at the same time if they're providing this service for

non-emergent patients, then it really frees up ambulance services to respond to true 911 calls, and also do the emergent transports so that they can be there and be available as needed.

A couple of things to emphasize is that not only our office, several attorneys that have looked at this with significant healthcare expertise, you've got now four major hospital systems and their in-house counsel that have thoroughly legally vetted this service. And trust me, you know, some of those have been very long in-depth processes legally vetting us, looking at all relevant federal and state laws and regulations and making sure that what Guardian is doing is legal.

Of course, the hospital systems don't want to run afoul of any laws and they also want to decrease their liability. They don't want to have any issues, nor does Guardian. So we've carefully crafted -- you know, Guardian has very carefully crafted policies and procedures and protocols to ensure that only patients that are non-emergent are transported. But the hospitals also have those same policies and procedures and protocols and checklists in place, and it's the medical personnel that's deciding whether or not the patient meets the criteria -- criteria for being truly non-emergent under Utah State law and suggesting that Guardian be used.

But then Guardian, upon arrival, they're verifying that under their own, you know, separate objective view that they still qualify as a non-emergent patient. And if there's any question, they'll refuse to transport the patient and say they need to be transported via ambulance. Because again, Guardian doesn't want that liability, you know, any of those issues whatsoever either.

We want to make sure that this ends up being, you know, a very positive, you know, thing for everybody involved. So everybody is being very careful on both ends to make sure that these are non-emergent patients.

You know, there is a driver and an attendant on every transportation vehicle, but there is not any medical observation. There's no medical care. There's no medical treatment. You know, this is simply an extra attendant.

Sometimes, you know, they are trained as a trained paramedics, sometimes they're not. Sometimes an attendant is a police officer. Let's say if they're going to a court appearance, but there is no medical observation, care or treatment going on whatsoever in these vans.

If an emergent condition does arise during transport, which that can arise with any of us at any given point in time, a 911 call is immediately placed.

First aid level care will be rendered by the people that are on that transport until 911 responds, but that is the only time that any kind of, you know, care would ever be rendered is only until 911 responds.

So I hope that that gives you a little bit of an overview. And, you know, I will mention we're certainly willing to answer, you know, some questions that this Committee might have, but I think that it's worth, you know, publicly noting that certainly some members that sit on this Committee, you know, may have, you know, a very inherent financial conflict of interest given that, you know, they're employed by ambulance services or may provide medical director services in some instances, right, for ambulance services, that may want to continue, right? It's tough when business is taken away and there's a competitor in the non-emergent sphere that otherwise maybe would go to, you know, the emergent sphere.

So I just want to make sure everybody's cognizant of that and certainly we're willing to answer some questions we feel are appropriate. But given that this is a private business and they're doing their very best to, you know, to run a business and do well, there may be some questions that we just feel aren't appropriate given, you know, given -- given the situation.

So with that I'll let you ask what questions you

feel relevant and decide how to proceed with that.

KRIS KEMP: Great. Thanks for the overview.

Questions by the Committee?

I had a couple of points of further clarification. You said that Guardian Transport mainly, is the term you used, provides behavioral health transports. What other -- what other transports would you potentially provide?

KRISTY KIMBALL: You know, I don't know that I can necessarily answer that. But I know that Guardian is not limited specifically to behavioral health, but they are providing non-emergent transports. So they're making sure that every patient that is transported specifically qualifies as a non-emergent patient under the statute, under the checklist, and those are the only patients they'll transport.

So although it may go outside the scope of behavioral health, right now their focus is behavioral health. But I'm sure that the range of, you know, potential individuals, you know, would be, you know, all over the board. I'm not sure there could be a definitive clear concise answer for that.

MIKE MOFFITT: I've got -- under statute 26-8a-305 there are 10 items listed that are by state law only an ambulance operating under a permit may transport.

Yet, you continue to use the word "non-emergent" when I think every provider in this room would -- would admit that emergent and non-emergent are part of the medical patient mix that they take care of.

I think you're putting a little to much emphasis on non-emergent when most alternate transportation services are nonmedical or assisted transport, and that's what this list is here for. And if your client is complying with this list, then I don't know why there's a problem. This is the law. This is what we support. This is what as a licensed provider I have to live by. And it should be what nonlicensed providers of transportation services have to live by.

KRISTY KIMBALL: And it certainly is. And if there's any concern that I was emphasizing the term "non-emergent", then I was just trying to use that term to be clear. These are not emergent patients. I certainly have that list in front of me, too.

The letter from Paul Patrick going back to 2013 where he's saying this is what I feel like a non, you know, these non-emergent or these patients that you can transport, here's what they can and can't do. And that's been specifically written into contract to make sure that this checklist absolutely includes all of those items. And if only those patients that qualify under the statute,

whether it's emergent -- I understand what you're saying. In addition to being non-emergent, that they also qualify by that criteria under the state statute for not having to be transported via ambulance service. So again, we've been very careful, very thorough on, you know, numerous, numerous counts.

JASON NICHOL: Will the -- or do the vans carry a complement of first-aid supplies of any kind?

KRISTY KIMBALL: I know the vans have like a little first-aid, you know, kit, that any lay person may have in the trunk of their car, but that is all that they have in the vehicle. And I think, again, you know, that's, you know, prudent for anyone to have in the trunk of their vehicle, and Guardian certainly has that in the vehicles, but that is all they have.

JASON NICHOL: I ask because you said that were there -- if an emergency situation did arise that they would render first-aid until the licensed provider showed up. Well, if we have licensed providers there, could there be a misinterpretation of them functioning as to what their certification is and what happens when equipment, if equipment were to appear on these vans and--

KRISTY KIMBALL: Well, equipment isn't appearing on the vans, just to be clear. It's not like they're equipped like a paramedic, you know, like a paramedic van,

they simply are not. So I think that they have really clear protocols in place to ensure that when 911 responds, that it's very clear that they're just rendering first-aid level, you know, immediate care until 911 responds. And there's no -- you know, there's no paramedic like equipment on these vans, you know, to get confused, confused with what the ambulances would carry on their vans -- or sorry, carry on their ambulances.

JASON NICHOL: Okay.

KRIS KEMP: Chief?

MIKE MATHIEU: Yeah, and as a provider of ambulance service, though, clearly, yeah, I have a conflict. Just like you have a conflict representing your client, it's the best interest in what you want for them.

And what, what I struggle with, and even before this particular situation, we used to run into the van transport services. And I'd talked with Paul about that because one of them was advertising nonemergency medical transportation, connotating, giving the illusion of some type of medical care was being provided or could be provided during a transport. When in fact, the reason I've been told the Bureau doesn't regulate these is because they're not medical transportation or they don't provide medical services during transportation. They provide disabled transport services, people who cannot get

into a vehicle on their own but need some form of transportation because of a disablement, not that any type of medical care is going to rendered during transit.

And so this appears to me, and this is what -- what concerns me a little bit, is when you state, and I've seen some of your advertising where you can put a paramedic on a vehicle to transport a patient, connotates you have the ability to provide paramedicine during transport.

And it's -- and it's from a statute standpoint and interpretation, I'm not asking for you to give me clarification, I'm saying to the EMS Committee we're getting so close that we don't know the difference between what an ambulance is and what it's not when you say it's a vehicle with the ability to provide medical care during transit. Because we can put a paramedic on it, we can put -- so now they're going to take a portion of what we do regulate, paramedics or EMTs, and place them on a vehicle for transport, but it's not an ambulance.

I'm getting confused. Because if I'm a healthcare provider in a medical facility, what is the difference between a paramedic on your vehicle and an ambulance? In terms of what's the capacity, capabilities, equipment requirements and -- and time and time again you've -- you've inferred that you are transporting

patients. Patients in my mind are people who need or deserve or need medical care under your stewardship.

If you're transporting a person because they're unable to transport themselves, and you say in the next term, well, I'll have someone in back, somebody will be driving, you're now talking about not providing medical care, but you have the ability to provide medical care.

I'm getting confused because I'm bouncing back and forth between the ability to provide medical care or no, we don't provide medical care. So if I'm confused, I'm sure the hospitals are confused as well.

And yes, there -- there is a financial element involved in this, but my -- I guess my biggest concern is that I think trying to manage healthcare costs is a very significant responsibility for all of us. And when the nonmedical transport services came online to take patients from point A to B and not provide medical care, I thought that was a great solution for those that didn't need the care.

But for people that need care during transit, now you're getting that much closer to what an ambulance does. And I believe the -- the Bureau does have the regulatory authority, I believe the statute does address it, and I've never seen anything other than the definition used as ambulance to provide transportation services and

provide care during that transit.

And that's what I'm trying to understand, the difference between the two and where that line really is.

And I do think it's a very important issue that the attorneys representing those trying to save dollars, those trying to help assist a business, those trying to protect what we're currently doing, shouldn't be the ones interpreting the interpretation. I think it is something that the state ought to look at and determine if they can clarify for all of us who have a conflict of interest where that line really resides in what connotates an ambulance and what doesn't. Because right now I've always been under the impression that anytime you provide care during transport, that's an ambulance. It looks like a duck, sounds like a duck, maybe it is a duck. And I think we're getting so close to that line, I think even caregivers, hospitals are being confused about what this is.

KRIS KEMP: I -- I would concur and that is exactly accurate from the perspective that I have as an ER physician. That when I read the promo advertisement and skill level, it mentioned EMTs and paramedics on board. It didn't say sometimes. It said EMTs and paramedics on board. And that's where I sat back and thought, well, wait a minute, what really is taking place here? And I --

I was confused.

And so I think these are all valid points that have been brought up as well. And we do have a few other things to talk about specifically in this regard. So, Jason, go ahead.

JASON NICHOL: I just have a couple of quick questions. Are all of the employees that have contact with your customers either EMTs, AEMTs or paramedics?

ALTON GILES: No.

JASON NICHOL: So you do have attendants that are -- that are not medically trained?

ALTON GILES: Yes.

JASON NICHOL: So you don't require your attendants to have medical training?

ALTON GILES: In that specific realm, no, but we also have behavioral health specialists.

JASON NICHOL: Okay.

KRIS KEMP: I think that's actually a really important point that I actually found is very beneficial for your service. I know when we talked specifically was -- was the mental health training that they put their drivers through.

JASON NICHOL: And the follow-up -- the follow-up to that is when -- when your attendants are out there, are they wearing a patch, a paramedic patch, an EMT

patch, or --

ALTON GILES: Paramedic, EMT, nothing.

JASON NICHOL: Okay.

KRISTY KIMBALL: They have Guardian EMS.

ALTON GILES: Guardian Transport.

MIKE MATHIEU: You are confused as well.

KRISTY KIMBALL: I'm sorry. I apologize.

MIKE MATHIEU: You're confused as well as to what you're doing.

KRISTY KIMBALL: I apologize.

BOB GROW: So you're doing transport out of emergency rooms to other facilities?

ALTON GILES: Correct.

BOB GROW: How is that not emergent?

ALTON GILES: Because they have been to an ER, they've been seen by crisis management, they've been seen by an ER doctor, and they've been evaluated. Now they're pink slipped or blue slipped, so they have no choice. They need to go from the LDS Hospital to Salt Lake Behavioral Facility.

KRISTY KIMBALL: So these aren't always patients being pink slipped or blue slipped. These may be patients that are just voluntarily, you know, needing maybe inpatient services, but they need to be transported. But they have been obviously, you know, cleared to be

discharged from the emergency room.

BOB GROW: They're cleared medically. They're not cleared psychiatrically. I guess another ER doc sitting over here listening, I've never heard of Guardian before coming today, so I'm not biased in any way, but, I mean, when I -- when I blue slip a patient, that to me means they have an emergent type getting admission. They're either psychotic or homicidal or suicidal. I don't know. I'm not sure. You know what I'm saying? You're not emergently taking patients out of an ER to an inpatient psychiatric facility, really jives well with me either, but --

ALTON GILES: Where do you work? What county are you in?

BOB GROW: Weber.

ALTON GILES: Weber --

BOB GROW: Weber, Davis.

ALTON GILES: Do you know how they're -- how are they taking most of your behavioral patients out, currently?

BOB GROW: Weber, it's through Ogden Fire.

ALTON GILES: And through Davis, how is it?

BOB GROW: Through the Sheriff's Office.

ALTON GILES: And what do they do to them?

BOB GROW: They will -- in Davis?

ALTON GILES: Yes.

BOB GROW: It depends. Most of the time the Sheriff's Office shows up when they handcuff --

ALTON GILES: Handcuff them, shackle them and put them in the patrol car.

BOB GROW: Yeah.

ALTON GILES: We're -- we're transporting in a secured medical van, transport van. You can't open the doors from the inside. You can't get at the driver to -- let's say for whatever reason they overpower the attendant and got up towards the driver, they can't get at the driver to get ahold of the wheel, anything like that and crash the vehicle. They can't open the doors and jump out of a moving vehicle.

This is -- we have -- we have set it up specifically for behavioral health in mind. It's not just, you know, ready taxi cab, we're going to throw somebody in the vehicle, let's transport them from point A to point B.

I mean, there's a lot -- the hospitals that we currently contract with have looked at this very closely because there's liability on their part also. They're not just going to send a patient with anybody.

KRIS KEMP: I have one other question for further clarification.

You mentioned in your presentation that hospitals are absorbing costs of non-emergent, but are paying emergent costs. Of the hospital representation here, are you aware of your hospitals getting bills from local transport services like your local EMS agencies being billed directly to the ERs, or do they go to the patients directly? Or I guess I could ask that of the agencies as well.

MIKE MATHIEU: We bill the patient directly.

KRIS KEMP: You bill the patient. Has anyone billed the ERs? So how are hospitals absorbing costs of non-emergents, but are paying emergent costs?

ALTON GILES: I think that would be something you would have to ask the hospital.

KRISTY KIMBALL: I can tell you that every single situation, we have four contracts, the hospital systems have looked internally at their own costs and what costs they end up absorbing from the specific transports they're contracting for and have seen how much they are spending versus how much it would cost to do the transport in situations that under the statute don't require that they use a paramedic. And they have determined through their own hospital systems that it is a cost savings for them and that they feel comfortable in certain specific scenarios using this service for that reason.

So, again, you have to, you know, look to all the different hospital systems to see why it is that they're absorbing much of these costs, you know, for these certain types of patients.

KRIS KEMP: Yeah, I think that's -- I think that's an interesting statement that you made, because it's -- it's not something that I'm finding has proven validated in at least the hospital systems that I'm working with. And so I -- I would just put that back out there as committee members is look at your own agencies and your billing practices and -- and then perhaps, although if you have hospital representation or you can communicate with your hospitals, if they actually look at where the -- where the billing goes through, because it seems to be a little bit different than what the current practice is at this point.

MIKE MOFFITT: I've got one more question.

KRIS KEMP: One other question?

MIKE MOFFITT: What -- what areas -- we were just talking about Davis/Weber County, obviously we talked about Salt Lake County, what areas of the state do you operate in?

ALTON GILES: State of Utah. The whole state.

MIKE MOFFITT: So you pick up patients everywhere?

ALTON GILES: Yes.

MIKE MOFFITT: Do you have -- do you have a license in Salt Lake City?

ALTON GILES: For?

MIKE MOFFITT: To operate an assisted transportation van?

ALTON GILES: Assisted transportation van?

MIKE MOFFITT: Yeah.

ALTON GILES: There isn't one. What we are currently doing, our specific set, there is not one.

MIKE MOFFITT: Well, you take your own legal advice and I'll go with what I've read of the ordinance, but I think there is.

ALTON GILES: Okay.

MARGY SWENSON: I have one more question. So when you're doing a transportation, how do you decide whether the attendant needs to have -- or what sort of attendant training is required for that particular transportation? Like whether you need a behavioral specialist or an EMT or a paramedic or a police officer or I guess those are the four I heard you say.

KRISTY KIMBALL: It's not up for Guardian to decide. The hospital system when they call and ask for the transport, they'll request an assistive person.

MARGY SWENSON: A paramedic or a police officer

or --

KRISTY KIMBALL: They won't -- no, no. They -- if somebody is trained as an EMT, that really has nothing to do with what they're providing. But if let's say you, me or somebody like that is going and they've got to take -- patients have to go to court appearances on Friday, they may want from their own standpoint to have certain attendants, like they may want there to be, you know somebody who's a trained police officer or, you know, certain attendants, or they may want extra personnel for their own purposes, and they'll request that extra personnel.

In terms of, you know, what Guardian has, just on the standard, you know, transport that they show up with, you know, that's -- they're just standard things. But the hospital systems themselves are designating, requesting if they want an additional personnel, you know, to -- just for their own liability sake to make sure that court appearances, there are enough personnel on hand to kind of follow around for the patients in court appearances, things like that.

KRIS KEMP: Thank you. Do you have anything further you'd like to explain or describe to the committee?

KRISTY KIMBALL: I think I would just like to,

you know, mention one thing that Mr., I think it's Mr. Mathieu, you know, mentioned. He said, you know, when you're -- when you're rendering medical care, and those are your exact words that you were using, then we're getting into this. That's the exact point. Guardian is not providing any medical care whatsoever.

We go by the statute and very carefully. I mean, even if a patient, you know, needs assistance with, like, they have an oxygen tank and they want assistance with, you know, the oxygen. No, not touching it, not rendering any care whatsoever.

That's the whole point. Guardian is not rendering any medical care to these patients. They're transporting patients that physicians and medical personnel have very specifically determined through their own protocols, qualify under the statute as not needing an ambulance and don't need, whether it's the hospital system or patients absorbing these extraordinary costs for transportation when it's not needed to be done by an ambulance, it's the physicians and the medical personnel that are making that determination, that no medical care is needed, and these patients qualify under the statute.

So, you know, I just emphasize there is no medical care whatsoever going on. Whether people are trained that may be hired by Guardian, whether they have

certification as an EMT is not relevant because they're not providing, you know, EMT services. They're not providing paramedic services. They're not providing any medical care whatsoever on these -- on these transportation services.

So, you know, I think that it's, you know, pretty clear. And again, we've vetted it through all that. There have been 15 attorneys going through this and making sure that every protocol is in place, make sure we are very, very careful about this.

KRIS KEMP: Well, we appreciate you guys coming out. We know you didn't have to do this. And we really do -- we do appreciate it. I think that the -- the issues are many that we -- you've heard kind of from the Committee the perspectives that we have. Obviously, there is an area that you are providing a service for and a business, and that's completely, you know, in the free market, and it's completely legitimate. You know, if you provide a service and you obtain the licensure, that's terrific. More power to you.

I think that the caution would be from the Committee, specifically to the department and the Bureau, is that there might be some lines that could be gray in some circumstances, and we just need to watch those closely. So if complaints do come up in this process that

there would be investigations made at that point.

GUY DANSIE: Right. And we've discussed that with them. One, make sure you document every case. If there is a complaint, it will go through our complaint compliance investigation or whatever we're calling them now, unit, and we would vet that through our channels that we normally have.

KRIS KEMP: And other service lines that provide similar, including other van services.

GUY DANSIE: Right. Right. We don't want to single you guys out and say that. That that's our process and they're aware of that and we've discussed that ad nauseam with them and these people.

KRIS KEMP: All right. Well, thank you again for coming out here and hopefully we weren't too aggressive with you. All right.

MIKE MATHIEU: Dr. Kemp, just -- just in that, I just want to respond to one of those comments that you just said, if I may. Because she did say, she says, if they are trained has nothing to do with what they are providing. And that's specifically her words. And she also said being an EMT or paramedic has nothing to do what they're doing. But on their website they say we have trained paramedics and EMTs. So if it has nothing to do with what they're doing, why is that on their website?

KRIS KEMP: Promoting --

MIKE MATHIEU: And I think that the whole use of anything to do with a definition we use under our regulations should not be used by them in any way, shape or form, such as paramedic or EMT. Because if it has nothing to do with what they're doing, they should not be using those terms to give the illusion that a paramedic or EMT is there, because that connotates providing care at that level that we regulate.

KRIS KEMP: That might be some useful advice and clarity as well. Thank you.

Back to -- is Dr. Hewes here? Terrific. Pediatric Vital Sign Abstract.

DR. HILARY HEWES: Do you want me to show pictures?

KRIS KEMP: Pictures are amazing. We have the ability to get access to --

DR. HILARY HEWES: I've got a zip drive and I've got a computer if anybody wants it. Your poster I can use whatever is easiest.

(Setting up)

DR. HILARY HEWES: Okay. I'll keep this brief. They just asked me to come today to give some results of a quality improvement project.

So I'm Hilary Hewes. I'm the EMSC Medical

Director and I'm an ED doctor at Primary Children's. And I recently helped present some information that was part of a quality improvement project done by the department here, the Bureau of EMSC. And we were looking at several years ago they had found some issues with food resuscitation and vital sign attainment, especially in pediatric patients, and came up with this idea of a project, process improvement, quality improvement project that involved not only teaching people about fluid resuscitation and looking at vital sign attainment in care, then going out and educating people about it and see if there was change over time. And as many people in the room are here, Matthew, Shari, Peter, this was not Bob, this is not something that I did. This is data that I said, wow, this is really interesting, you should share this. So I cannot claim credit for this information. This was other people taking on the initiative.

So I can talk to you a little bit about it while we can see if we can get the pictures up. The graphs are really nicely done.

So just in general about 10 percent of transports are pediatric transports. And there's been a lot of studies that have shown that people aren't very good at looking at pediatric vital signs. They might take heart rate or respiratory rate, but don't often get what

we consider the four critical vital signs, respiratory rate, pulse ox, heart rate and blood pressure in a lot of pediatric transports. And they looked at the retrospected EMS data, and up to 70 percent of the time they weren't getting blood pressure, especially in young kids. So blood pressure was one of the main vital signs that we were kind of missing out on.

And we know when you look at certain conditions, like bad closed head injuries or shock, if you don't treat hypotension or low blood pressure, or if you don't treat low oxygen levels, it can lead to bad outcomes.

And there's actually a paper published out of the University of Utah/Primary Children's Hospital looking at the outcomes of kids with head injury who were not treated for low blood pressure that showed worse outcomes. And we said: How can we make this a little bit better?

So the objectives of the process were to look at the practice.

Okay. Thank you. So the objectives were to look at the EMS practice in obtaining those poor vital signs in transport of patients between 2007 and 2014, and these were on pediatric patients, and then to look at these educational interventions that we did to see if it made a difference in how people were getting vital signs. So this is part of a combined state trauma and EMS

performance improvement project.

And the educational interventions that were developed -- let me see if I can go through these here.

The first one was, we looked at the vital sign data and we went around -- each year there's an EMSC coordinator retreat where we talk with our EMSC coordinators in different regions of the state and talk about different pediatric topics. And we went to the coordinator retreat and we said, "Hey, this is how often your area is getting vital signs, this percentage of the time, this is where we can do improvement."

And then those EMSC coordinators took that information back to their EMS providers and said, "Hey, guys, we are really doing great with respiratory rate. We never get blood pressures. We're trying to get better vital signs."

So that was kind of the first just early dissemination of this information. And then Dr. Taillac took this information across the state in about four to five other talks, that just again emphasized the importance of pediatric vital signs, why do we get them, how -- sometimes about how to get them and why it's important. This information about how we weren't getting them all that often.

And then this group took this -- made this great

six-hour program, and it talked a lot not just about vital signs, but on how do you do quality improvement, how do you do process improvement and did education about that as well.

And then had people like Tia, Darren Bull and Howard Kayish other people with pediatric experience teach people how do you take a blood pressure in a screaming two-year old? How do you get an accurate pulse ox on a kid who doesn't have good profusion? And gave people some kind of tricks of the trade to help improve how often they're getting vital signs as well.

So it didn't just do this is what we're doing, we want you to do better. They also talked about how do you measure improvement and how you can actually get better vital signs on kids.

So we looked at the trend of documenting these vital times that were in all four categories. And what we found is that we actually did the best improving how often we looked at the pulse oximetry across all age groups, and we improved getting respiratory rate and heart rate to over 90 percent across all age group after these educational trainings.

Blood pressure we got better on, but we still don't do great on young kids, especially kids under three. We're still doing blood pressures in less than 50 percent

of transports.

And we do feel that those educational interventions correlated with increase in vital sign attaining. I'll show you the graphs which are really good and helpful.

So there are some really pretty colors. I'd like to thank Shari for putting these all together.

SHARI HUNSAKER: Oh, these are Matthew's.

DR. HILARY HEWES: These are Matthew's? Matthew, I'm sorry. Both of you guys for puttings these all together. It's a joint effort.

So what we could see is that you can see age on the bottom access and then how often, what percent of the time they were getting blood pressures on the Y access.

So we were counting everything after 2010 is after those interventions. And you can see the orange line with the circle is 2011, and you can see that jump in how often we're getting blood -- blood pressures after that time. Basically so 2011 are up, we're getting blood pressures much more often, especially in our older kids.

You can still see the younger kids it's not happening quite as often. A lot of this we feel, when -- is not necessarily any transport's fault. Sometimes you have a one-year old and you don't have a neonatal cuff. You only have a child cuff and an adult cuff, and it can't

take a blood pressure on a three-month old if you don't have the right cuff. So some of this is equipment issue and it's not necessarily that people didn't try. But it's still just not happening as much as we would like.

Pulse ox, this was the one we saw the most improvement across all age groups. It used to be about 60 percent of the time, now it's upwards of 80 percent of the time.

Respiratory rate went from 60s to 70s up into the 90s. And respiratory heart rate are those two that kind of increased the best over time. Looking for that orange line is the break between 2010, 2011.

And then heart rate again, we're getting above 90 percent of the time getting these vital signs on transport.

And I completely know that sometimes you have a short transport and it doesn't seem like -- your kid looks really well, you don't feel like there's that much need to take a vital sign on these kids, or you have a screaming kid and you're just doing your best to survive, but, you know, I think the argument is on -- on any transport where you can, it would be great to get the set of vital signs because it's pretty important information for us when the kids arrive, especially looking at trends over time. And certainly any kid with a trauma or any kid you really feel

has an acute serious illness, documenting vital signs and trending them over time and including things like blood pressure are really important.

So we came to the conclusion that vital signs are a critical part of the assessment in the pre-hospital setting. EMS providers in the state of Utah have really done well improving how often they're getting vital signs between 2007 and 2014.

Blood pressure still is our challenge. And I do think part of that is an equipment issue. And I wish that every rig had four different blood pressure sized blood pressure cuffs, but I know that doesn't always happen.

And the educational interventions, much of it was pretty simple. That six-hour program was definitely more time consuming. And Dr. Taillac certainly put time in going around during his aspect of the program. But most of these weren't huge efforts or required a lot of money, and they made a big difference.

But we still have some goal. Our state goal is to obtain the four vital signs in greater than 90 percent of pediatric transports, so we have a little ways to go.

But I just wanted to share that data. I think this is a really wonderful group effort and I think we've made a big difference in the area that could cause improvement in overall health of kids in Utah. And so I'd

love to thank all of our providers and all of the group that participated in this program for a job well done.

And if anyone has any ideas of future things they'd like to look at with pediatric transports, I'd love to hear about them. I'm always up to hearing any of the ideas people have. And I can take any questions.

KRIS KEMP: As far as using this data for process improvement, what would be the plan? Are you trying to get appropriate sized blood pressure cuffs on every rig or what's the plan?

DR. HILARY HEWES: So we have a couple plans. So we had a representative of the Utah legislature come to one of our last EMSC meetings and talk with us about -- she didn't realize things -- that funding is an issue for certain things like equipment. And so she showed interest in helping maybe better stock our rigs. I don't know if that ever will happen, but she at least showed some interest.

And then we as the EMSC group are working on getting this data now, the kind of data broken back down into districts and going back out to each EMSC coordinator and distributing information or also maybe putting it up on a website where different agencies can access, or, I don't know if it's going to be by agency or by region, they can access how much they are doing at this point, how

improved -- how much improvement have they seen, where are the areas for improvement, so try to close that feedback loop.

SHARI HUNSAKER: Hilary, we created some reports in Polaris. So whether you're using Polaris or your own data entry or you're just uploading information into Polaris from another software, we did train as part of that six-hour course, agencies on how to go into Polaris and run the pediatric vital sign report so you can see how you are doing compared to the state standards.

And that report even allows you to get a list of the patient care reports that are looked at in that report. So that's part of the loop closure. And we are going to be sending out those instructions again as we publish the results of the work that we did.

We've gotten some really good traction. Hilary presented this at the Western State's Pediatric Trauma, and won second place. We presented it to the NASEMSO and the State won first place for the abstract and the project in and of itself.

So we want to capitalize on that and spread the word and say, oh, by the way, look at these pretty graphs. Would you like to know how you are doing? You can run this report and find out.

DR. HILARY HEWES: And my manuscript actually

got accepted for publication in the Journal of Pediatric Surgery as part of that trauma conference. It's kind of an easier road to publication.

And so I -- I think that not only if we got an interest here, I think when this has been shared nationally, there's been interest because this is not a problem that's unique to Utah. So I think it is generating some interest just in general about how can we improve pre-hospital care for kids.

JASON NICHOL: Is there any correlation or did you see any correlation in your data in regards to transport time and the obtaining vital signs? So if there's over a --

DR. HILARY HEWES: Yeah, a certain minutes --

JASON NICHOL: -- a ten-minute transport time, is there a higher percentage of getting all four vital signs or a lower than 10-minute transport?

DR. HILARY HEWES: So that -- that would definitely seem to make sense. Or if it was, you know, if it was a paramedic team going out where you think it might have been a sicker patient, was -- was that different than, you know, maybe an EMS basic crew going out.

But I didn't look at that data specifically, Matthew, I don't know if we've broken it down -- we didn't break it down for the study.

MATTHEW: I didn't do the analysis for this, so I don't know.

DR. HILARY HEWES: Was it Josh?

SHARI HUNSAKER: We could.

JASON NICHOL: My only thought with that is, that sometimes, you know, I don't know, remember if you said or not, but people just simply not doing it is different than having it in your set of skills that you are going to do --

DR. HILARY HEWES: Just not having time.

JASON NICHOL: -- and just not having time to get there.

DR. HILARY HEWES: You know, I think we actually talked about this when we were writing up the analysis. I think that if we looked at type of injury, you know, obviously --

JASON NICHOL: Acuity --

DR. HILARY HEWES: -- if this is a little kid who sprained her ankle and the school called, I don't really care -- I mean, I care what her blood pressure is, I don't care that much versus if it's an hour transport, you're coming, you know, over from Park City or Heber and you've got a sicker kid, I do think transport time would be -- would -- would be influential. And I do think severity of illness would be influential. We just didn't

break that data down yet.

JASON NICHOL: Yet.

DR. HILARY HEWES: And I don't know if -- I'd have to talk to Matthew or talk to Shari and see if we can.

JASON NICHOL: I think that would be -- I think that would be very interesting and very informative.

DR. HILARY HEWES: But I would love, like I said, if anyone has any other good ideas for pediatric pre-hospital care, please let me know, I would love to help. And feel free to email me or contact me if you have an interest.

Yeah, Matthew.

MATTHEW: When was the intervention?

DR. HILARY HEWES: So it started -- 2010 is when we started talking to the EMSC coordinators. Basically all through 2010, 2011 is when we started doing all those things. But it continued on from there, but that's when we started doing all the talks.

MATTHEW: So it was about -- the intervention was over a three-year, four-year period?

DR. HILARY HEWES: Yeah, it was probably most concentrated in that first period of time. And I'd asked if there was a change in Polaris or a change in the way things were entered, and people didn't seem to think there

was, but I'm not as familiar with Polaris to say was there a way it was made easier that data was -- but Shari didn't think so. You know, was there some other bias in there that made it so things went up during that time period. People didn't seem to think so.

SHARI HUNSAKER: And so we just broke it out for the NASEMSO purposes of before the training and after the training.

DR. HILARY HEWES: So it's not -- this is not a super high level randomized control trial to prove those interventions affected things, but I do think there's at least a trend that after that time period when we started talking about this more, maybe it went up into the forefront of people's mind a little more, and people realized. And again, it might not be unique to Utah, but it might have been a national push to recognize we need to take more vitals on kids.

Any other questions?

KRIS KEMP: Great.

DR. HILARY HEWES: I don't think this microphone actually worked.

KRIS KEMP: Thank you.

DR. HILARY HEWES: Thanks you guys. Sorry about the computer.

KRIS KEMP: No problem.

So that brings us to the round table discussion. There was a couple of points that we brought up in the executive session that we thought would be wise to talk about at this point. The IA issue we've already talked about as it came along.

So funding for the federal and the Medicaid assessment. Guy, do you want to speak to this and process, and what's happened, where we are with that and what to expect in the future?

GUY DANSIE: Yes. We just -- we've just -- we're starting to get the data and it's being submitted. The assessments are going out. I think we finally identified a few issues on -- on data quality and making sure that we're counting all of our apples and not oranges. And Shari is actually here, so I'm grateful for that. Because I know Ogden was one of the agencies and Mike was one of the ones that worked extensively with this.

SHARI HUNSAKER: Eric is one of my new best friends.

DR. PETER TAILLAC: Quickly, would you just give kind of a quick overview of the topic? I'm not sure everyone knows what it's about.

GUY DANSIE: Yeah, and I'm just babbling. That's good to focus me.

In our state legislature this past year, they -- I say they because I look Mike down here, he was instrumental, Mike, and I believe Mike Moffitt as well, who were involved in this process. They developed a system to assess our EMS providers an assessment, a tax if you will, a fee, for every one of their ground transports. This -- this fee goes into a pool of money and it's used to draw down more federal dollars for Medicaid. And then those are disbursed out. So our Medicaid reimbursement is at a much higher rate than it was in the past. That's kind of the nutshell of it.

Does that answer -- anybody any questions on that?

KRIS KEMP: How much? How much is the fee? How much is the --

SHARI HUNSAKER: It's $5 per transport.

MIKE MATHIEU: Well, it's a general number. It's more than that. The way it works out is the match to the federal government is .2976 percent. So essentially 30 percent.

And the way it works is each quarter the amount of additional paid Medicaid dollars at the new rate. The former rate was 142.72, the new rate is 696.

So what the state Medicaid office is doing, is it totals up the amount of additional payments, not the

142 initially, but the 553 that's the difference between those two numbers I just stated. They total all that up, and they come up with a number of -- of how much additional dollars they paid out. And it's roughly one and a half million dollars.

They take that times it by -- excuse me, first they add the one quarter of their administration fee, which their annual fee is 20,000, they -- they put in 5,000 of it per quarter. They come up with an aggregate quarter total.

They take that total, times it by the .2976 percent, that's the match requirement. They take that match requirement, divide it by the number of total ground ambulance transports that occurred throughout the state, 18 months previous or 2014.

They take that number and that derives that quotient that Shari is saying that $5. What that equals to is 25 percent of the assessment for each year, or for the entire years, because we'll get this assessment every quarter.

The assessment for October reflects the amount of additional new dollars paid from July 1st to -- to September 1st that are -- excuse me, September 30th. So three-month period of time that have all adjudicated and paid claims. So there's a little lag time in this first

quarter.

The other question that has come up is the clarification of the NEMSIS numbers or the Polaris numbers in terms of allocation of how much each portions or entities is -- reflects that match requirement. And that's what's being qualified right now. Because apparently the 95,000 ground ambulance transports that were completed in 2014, some of those numbers weren't accurately reported and accounted for, and so they're trying to clarify that before they send out the assessments.

GUY DANSIE: See, I told you he could speak to it better than me.

So anyway, we're just working through that process now. I don't know if there's any specific questions.

One of the issues I think we identified is that there were three small agencies that were not even billing Medicaid. They're being assessed, and so they're losing a little bit of money. So we're going to work with them, encourage them to try to collect their Medicaid dollars.

We had some numbers that were double counted. There were a couple of instances where we had paramedics aboard, like to assist a different agency. Those were counted in their aggregate and assessed, and they

shouldn't have been. And I think that was the primary issues.

Some of the questions I had, and Shari is here to help me with this, is the types of transports that are being assessed. And just for the record, just state it and then I will --

SHARI HUNSAKER: Within NEMSIS there is a data element called disposition. And I was asked to provide a report for the total number of runs reported by every agency in the state during 2014, where the disposition was treated and transported by this EMS unit. And that's the number that I provided.

GUY DANSIE: Right.

SHARI HUNSAKER: But if I've got agencies that are underreporting by 30 or 40 percent because of data issues, their numbers are way skewed. And in the case of Ogden, they've created some custom disposition values. And they were mapped to the treated and transported by this EMS code in NEMSIS, and they shouldn't have been. And so they were overassessed.

GUY DANSIE: Yeah. And -- and honestly I -- I thought in this whole process, things have gone very smoothly. We haven't had a lot of feedback, any, you know, big issues on our end. I think there were some of the agencies -- I met with the Medicaid folks over in our

Department of Health earlier this morning, and Dean and Paul and I, and we realized there are a few discrepancies, there's a few issues. Some of the agencies were not aware of this, and I don't know how they fell through the cracks because we have been harping on this for -- for some time.

But I will be the point person and we will -- for any questions on -- on the provider side, and Shari and myself and some of our folks can help on the provider's side. On the Medicaid technical side, we have some contacts there and we can work through those issues.

I think our biggest issue is just cleaning up our data and making sure we're talking apples to apples on -- on all of the data.

SHARI HUNSAKER: And when I'm aware of the -- as I become aware of data discrepancies, I'm working with those individual agencies to get their numbers cleaned up.

Unified Fire Authority resubmitted all of their 2014 patient care reports. And Josh eliminated all the duplicates. So now I have an accurate number for UFA for the year.

Eric has been working with Image Trend to get their mapping cleaned up. And then they'll edit their PCRs and I can clean up those numbers. You know, all I care about most passionately is that the data is good and accurate.

GUY DANSIE: Right. And fair for everybody.

SHARI HUNSAKER: Yeah.

KRIS KEMP: You mentioned something about a fact sheet.

GUY DANSIE: Oh, yeah. One of the tasks that we were just tasked with this morning is to put together maybe a fact sheet, a frequently asked question sheet and put that on our website. And so what I've agreed to do with Steven Jones of Medicaid is put together some questions. And if any of you have specific questions, I think I have a pretty good handle on what some of those are, some of the things we've been discussing right now, and then putting together that formula with the numbers, you know, so that they can understand what's going into this, and what they're getting back out, and how and why that works.

I think the main thing is each provider probably should look at the -- at the numbers that they are being assessed on and the reimbursements and determine if those numbers reflect their numbers accurately, or if there is a discrepancy, then we need to resolve that.

So that's -- that's what I wanted to do, was put together this sheet of information for the providers so that they could look at that, figure out what they should be paying.

KRIS KEMP: When can we expect that?

GUY DANSIE: Oh, I'm going to try to work on it probably in a week.

SHARI HUNSAKER: You keep looking at me like I'm --

GUY DANSIE: I'm looking for a lifeline here. No, I'm going to be working on it. It's new to me too, and I look -- I look at Mike. Mike is probably the expert, if you will, in the state on this. And he's worked on it probably more than anybody else. And then the Medicaid folks, they -- they had questions for us as well. You know, they're trying to figure out how to deal with this new animal, that they're -- that they're trying to cage, and they -- they don't know all the pieces. And we're trying to communicate more clearly with them, like -- like, for instance, I know Iron County was changed to Gold Cross and they have those broken out separately. There's a lot of just this housekeeping things.

MIKE MOFFITT: That's it. South Salt Lake didn't change. Don't give me their -- I'm not paying their --

GUY DANSIE: Okay. You won't get theirs. All right. But anyway, there's just a few little glitches that we found. But as we identify those, let me know. And I probably need to send out a letter once we get the

fact sheet up to all the directors letting them know, and -- and then we can start dealing with individual problems if there are any.

SHARI HUNSAKER: Then as part of this task force on data, we can look at developing a standard method of reconciling so the agencies, you know -- somehow we need to get them to communicate with the state. Yeah, I had 800 runs last month, but the state is only showing 600, what happened to those other 200 runs? Why didn't they come across?

GUY DANSIE: Like a quality assurance crosscheck.

SPEAKER: I just had a quick question. I guess not a question, maybe a suggestion to the folks who are sending out the invoices, because we all received one which was fine, and then an issue and got taken back and apparently was wrong. But it never had the amount that was being assessed or the number of transports, it just had a total bar amount. So I can't verify that the data's quality is good unless I know the fee I'm being assessed. Add that added onto the bill, that would be much appreciated.

GUY DANSIE: That was one of the issues we discussed. And, you know, I think they just send out the bill, here it is. And everybody was scratching their

heads, what goes into this and how did you come up with this number. So that's why I was going to post the formula. Then you can look at the number of runs and make sure that we're all clear on what types of runs that -- that Shari just described. There's been some foggy thinking on what types of runs go into this number, including myself, I wasn't sure about that, so.

MIKE MATHIEU: Guy talked to Steve Friday when that went out. And he said he agrees, he thinks that's a great idea, he'd send that data out, but I think they want to make sure it's clean first before they send it.

GUY DANSIE: My mystery phone is ringing.

JASON NICHOL: Answer it. Ask them who the speaker is.

KRIS KEMP: In the meantime we'll continue -- there's one other round table discussion that, Dr. Taillac, you wanted to bring up.

DR. PETER TAILLAC: Just briefly, the State Protocol Guidelines Committee has reconvened to review the protocol deadline's date. That process should be done and we hope within six months or so, and we'll be bringing them to the EMS Committee for review and approval. So more to come. I don't think they're going to change very much, the format won't change. Sort of just updating based on some national guidelines that have come out and

some new information, et cetera.

KRIS KEMP: Terrific. Any other round table items? Information?

GUY DANSIE: I have one more. Sorry, and I should have mentioned this earlier.

JASON NICHOL: Whose phone is it?

GUY DANSIE: It's -- actually you're all dying to know. It's Alton Giles' employee, the other gentleman that was sitting here. At least we found the owner.

One other thing, tomorrow we will actually have -- we -- we put forth a rule for the grants, and that went out to public comment. The comment period closed last week and it can be made effective tomorrow. I haven't submitted it yet. But probably the next couple days it will be made effective.

And it -- it's mostly clarity and some of the -- it was vetted through this group earlier. I just wanted to give you an update on that.

KRIS KEMP: Okay. Any additional assignments for our subcommittees?

JASON NICHOL: Task force.

KRIS KEMP: We're going to form the task force for data, right?

SHARI HUNSAKER: And you're going to tell me who's going to be heading that up?

KRIS KEMP: Yeah. The department will help us work through that detail.

GUY DANSIE: We will?

SHARI HUNSAKER: I mean -- I don't know how --

GUY DANSIE: I would assume Shari would be our point person for that.

KRIS KEMP: Right. But members of the committee, do we have any volunteers that would like to sit on that data?

JASON NICHOL: I'll just throw it in with all the other subcommittees. No, I want to. I do. I want to.

SHARI HUNSAKER: It doesn't matter to me. It -- I just want to know who with, you know, that I need to work with from the committee.

JASON NICHOL: Jeri?

JERI JOHNSON: I'll do it.

SUZANNE BARTON: So take your name off, Jason, off the record?

JASON NICHOL: No. No. I just don't like to do anything without Jeri.

KRIS KEMP: Any other volunteers?

MIKE MOFFITT: I'll vote too.

SHARI HUNSAKER: We had a task force. We did have a task force originally together several years ago.

MIKE MOFFITT: Mike will do it too.

SHARI HUNSAKER: Would it be helpful if I sent that list of who was on the Task Force in the past?

MIKE MOFFITT: No. No. We're just -- this is a sub -- a committee, a task force of the committee and, you know, I'll be on it. Mike will be on it. Jason, you volunteered.

JASON NICHOL: Jeri.

MIKE MOFFITT: Jeri. Awesome.

KRIS KEMP: Great.

MIKE MOFFITT: That gets field providers and -- and if we need, you know, somebody from the hospital side of things.

JASON NICHOL: Mark.

MARK ADAMS: Yeah, I'll be happy.

KRIS KEMP: All right. And then the professional development assignment, you'll get the IA language probably in the next couple of weeks. We'll try to put it together, and then we'll get it out to you guys and we'll also get that through the Rules Task Force.

Other than that, there's nothing else from grants for assignments and then operations? No?

GUY DANSIE: Well, we're still working on projects, right?

KRIS KEMP: We still have that.

GUY DANSIE: And the vehicle thing will pop up again so --

KRIS KEMP: Please note your 2016 meeting schedule is listed. Your next meeting is January 13th, 2016 at 1 p.m. here.

And I heard a motion to adjourn.

JASON NICHOL: Motion to adjourn.

MIKE MATHIEU: Second it.

KRIS KEMP: All right. All in favor say aye.

COLLECTIVELY: Aye.

(Meeting was concluded at 2:56 p.m.)

C E R T I F I C A T E

STATE OF UTAH)
)
COUNTY OF UTAH)

This is to certify that the foregoing proceedings were taken before me, Susan S. Sprouse, a Certified Shorthand Reporter in and for the State of Utah, residing in Salt Lake County, Utah;

That the proceedings were reported by me in stenotype, and thereafter caused by me to be transcribed into printed form, and that a true and correct transcription of said testimony so taken and transcribed is set forth in the foregoing pages, inclusive.

DATED this 2nd day of NOVEMBER, 2015.

_____
SUSAN S. SPROUSE, RPR, CSR
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